



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Administration
DIVISION OF STATE EMPLOYEES WORKERS' COMPENSATION
One Capital Hill
Providence, R.I. 02908-5866

ACCIDENT WITNESS AFFIDAVIT

Date:

This is to certify that I was a witness to the accident / incident of:

Name:

Date of injury:

Time of injury:

Location of injury:

Description of accident / incident:

Witness (Please print your name)

Signature of Witness